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AUTHOR Kelley, Verne R.; And Others
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ABSTRACT

In an effort to prove that mental health services can be lay administered, a training program was implemented in the rural areas of Cedar County (October 1972-April 1973) and Iowa County, Iowa (October 1973-May 1974). Recruited via personal or telephone contact, 20 trainees were selected who demonstrated they: were good listeners; did not impose their opinions on others; were concerned with people; accepted another's point of view; had no extraordinary anxiety; wanted to gain additional skills; and were area residents, committed to stay with the entire project. Conducted twice weekly for 3 hours, 24 training sessions included role playing and programmed application. Key training principles were: assumption that people can change; avoidance of past history; emphasis on listening; avoidance of responsibility taking and encouragement of independence; avoidance of the "blaming others" tactic; discouragement of belief in "The Answer". Additionally, considerable time was spent on Carkhuff's interpersonal variables (empathy, communication of respect, concreteness; genuineness, self-disclosure, confrontation, and immediacy of relationship). Evaluations (the Personal Orientation Inventory, Carkhuff's Discrimination and Communication Indices, checklists from programmed patients, and trainees' personal reports) indicated that rural lay people can be trained to render mental health services. (JC)

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RURAL COMMUNITIES LEARN TO HELP THEMSELVES*

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NMSU
E.R.I.C.

Verne R. Kelley
Mid-Eastern Iowa
Community Mental Health Center

Eugene F. Gauron
University Of Iowa
Department of Psychiatry

and

Patricia L. Kelley
University Of Iowa
Department of Psychology
Research and Training Clinic
and School of Social Work

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EDUCATION & WELFARE
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I. INTRODUCTION

Because of a perennial scarcity of trained professionals to provide mental health services in rural areas, it is desirable to develop alternative methods of service delivery. One solution to the shortage of helpers is to train lay and non-mental health professional people in the local community to become effective change agents. We set out to develop an intensive training experience which would be instrumental in creating a first line of defense at the local community level aimed toward problem prevention and crisis management in family groups.

One way small communities have attempted to meet their mental health needs has been to bring in outside professional consultants to provide direct services to disturbed persons and families. This method is unsatisfactory because the need for service usually outstrips the amount of service time available (Beier, Robinson & Micheletti, 1971). Another technique has been to use the professional consultant to educate and supervise the existing community counselors, usually ministers or physicians (Shapiro, Maholick, Brewer, Townsend, 1966). Many other persons, such as housewives and students represent resources that can be utilized for rural community mental health programs. The literature suggests that socially intelligent lay persons can serve effectively as counselors and that extensive professional training is not required in dealing with emotionally disturbed children and adults, and even chronic mental patients (Rappaport, Chinsky, & Cowen, 1971; Wahler & Erickson, 1969; Cowen, Zak, Izzo & Frost, 1966; Poser, 1966; Carkhuff & Truax, 1965; Rioch, Elkes, Flint, Usdansky, Newman & Siber, 1963).

The recently reported Susanville project (Beier, Robinson & Micheletti, 1971) represented an ambitious attempt to extend the mental health services in a small community by mobilizing the community toward self-help. The investigators in this project trained adult lay members of the community and high school students to work with families who had children with school problems as s result of family stress. The focus of training was to teach families to solve their own problems. The results of that study were very encouraging. The trainees were quite enthusiastic. Of the 15 adults who participated fully in the training, 11 planned to continue working with troubled families; 5 of 7 fully trained high school students planned to continue seeing high school students with problems. Four of the seven target families that were available for exit interviews indicated that they had learned to handle their problems more effectively.

II. PROCEDURES

1. The Rural Area

In the first year we implemented the training program in rural Cedar County, Iowa. The economy of Cedar County is based on agriculture and associated commercial services. Cedar County ranks first in Iowa for producing pork.

Cedar County's population is 17,489 and Tipton, its largest town and the county seat, has 2,877 people. Most communities in Iowa are similar in size. Ninety-two percent of all communities in Iowa (877 of 952) have populations less than 5,000, and 96 percent (911 of 952) are under 10,000 population. We felt that this demographic pattern was probably typical of the Midwest.

We chose Cedar County because the project director was acquainted with it and had working professional relationships with several of the

potential trainees. Cedar County was served by our mental health center. One day a week the project director provided outpatient, aftercare and consultation services in a small office complex with the county public health nurse and the sanitarian in the courthouse. We had become established and accepted in the area. Working professional relationships had been developed for three years with public health nursing, welfare, the community action program, schools, corrections, physicians and attorneys. We began recruitment of trainees with that group and also followed up their suggestions for other potential trainees.

2. Selection of Trainees

We aimed our recruitment efforts at persons who were "natural helpers" on one of three levels: 1) official help-givers in the county; 2) professionals in private practice; and 3) an invisible level of helpers -- friends, relatives and others who are helping people regularly without any special recognition for doing it nor any training in it.

The criteria established for selection of trainees were: good listeners, did not impose their opinions on others, showed concern for people, accepted another person's point of view, displayed no extraordinary anxiety, wanted additional skills, lived in Cedar County, were in a position to help people, operated at a responsible level of functioning, and made a commitment to stay with the entire project.

Our recruiting approach was either face-to-face or by telephone. We described the training project in this vein: "This is a mental health training project. Our aim is to demonstrate that residents of rural areas can be trained to meet some of the mental health needs of families and children they ordinarily deal with and help them to learn

how to solve their own problems. We feel that the project has implications for rural communities that cannot expect to be able to recruit and support their own professional mental health personnel. There will be a minimum of lectures. It will consist more of role playing and group participation. We plan to involve about 20 persons in training. There are three trainers and one evaluator from the University who will come out to Tipton to conduct the training program. There is no charge to participate."

To recruit 20 trainees we contacted 38 persons. It was interesting to note how active and committed many people were, particularly in rural life which is presumed to be mostly uneventful. Half of those not joining us said they were over-committed and "didn't have the time." These were primarily attorneys and clergymen. Others had personal reasons such as retirement, too tired at night, going on vacation and had baby-sitting problems. Two refused clearly because they feared what we would expect of them after the training -- that they might get involved in problems they could not handle.

The twenty trainees consisted of five housewives, two high school students, a physician in the general practice of medicine, the director of the county welfare department, a case aid in the same department, a public health nurse, her secretary-receptionist, two outreach workers for the Community Action Program, a beauty shop operator, a funeral director, a high school guidance counselor, a minister, an automobile service station manager, and a school nurse.

Prior to training each person received a letter that described the project orientation and focus, introduced the project staff and listed their qualifications. We pointed out that the trainers and the evaluator were not employees of the mental health center. They were

University of Iowa faculty and staff. (Gauron, Rawlings, and Canter are psychologists; the Kelleys are social workers.) We also gave each trainee a research consent form to sign. All signed it.

3. Training Program in Cedar County

The training sessions were conducted once weekly for two hours at the Methodist Church in Tipton, Iowa. General procedure called for the three trainer-consultants to be present at each meeting plus the project director. However, there were occasions when one of us missed a session.

The program extended over seven months from October 1972, through April of 1973, for a total of twenty-four training sessions. The sessions were divided into those devoted primarily to training and new learning (18 sessions) and those devoted to application of the material learned in actual contacts with clients, supervision by the professional staff, and discussion of problems in seeing help-seekers (six sessions).

Of the 20 trainees, one terminated after attending only a few sessions. Three others missed nearly one-third of the training sessions. The attendance for the remainder was fairly good. We ordinarily had an average of 16 per session.

The basic philosophy of the training program was action-oriented with heavy emphasis on the importance of previous learning in maintaining maladaptive behavior patterns and new learning in modifying behavior patterns. Some key principles presented to the trainees to guide their interventions included:

(1) Question "I am as I am" statements. These are ways of avoiding change. Assume that all people are capable of changing and modifying their behavior.

(2) Avoid becoming absorbed with historical excuses or reasons for present problems -- this is a dead end. Rather, focus on what is happening now to continue the present problem and what can be done to change it.

(3) Really listen to others in an effort to understand what they are saying. Good listening is hard work and takes considerable effort.

(4) Do not give advice, present solutions, or take responsibility for the person seeking help. An important goal is to encourage people to become responsible for themselves and develop their own solutions. Furthermore, it is critical to encourage people to develop options or alternatives to present ways of behaving.

(5) Be alert to efforts to blame another, usually a significant person in the past, for the present situation. Blaming is one manifestation of failure to take responsibility.

(6) Discourage people from the belief that "THE answer" will solve all problems or that their situation will be remedied by magic or by a magic helper. Rather, problems are solved singly through following a planned course of action. Encourage people to develop specific goals and to pursue these goals until they are attained.

In addition to these basic principles, considerable time and attention were devoted to seven critical interpersonal variables of good helpers identified by Carkhuff: empathy, communication of respect, concreteness, genuineness, self-disclosure, confrontation, and immediacy of relationship (Carkhuff, 1969, 1972). Carkhuff has conducted extensive research into the outcomes of helping and had identified these seven variables as distinctive of good helpers (Carkhuff, 1972). He has argued that training programs with both professionals and non-professionals might profitably focus on teaching and practicing these variables

Instead of teaching the student to help or to do psychotherapy, Carkhuff has recommended that we teach the student to be more empathic, respectful, specific, confronting, genuine, self-disclosing, and immediate and in so doing he will become an effective helper. An additional advantage of focusing on these research-identified helper variables was that it simplified the evaluation process and allowed us to focus on particular areas of trainee behavior that should be modified as a result of the training process.

The first three training sessions were devoted to introduction of the staff, overview and orientation to the program, introduction of the trainees to each other, completion of the pre-training test measures (FIRO-B, POI, discrimination and communication exercise) and efforts on our part to increase comfortableness and trust while building a group that would be able to work together. We introduced several exercises -- name tags on which each person wrote five important things about himself (which others read), a Peak Sensory Experience exercise in which each person wrote three of his favorite experiences in each of the areas of sight, sound, taste, touch, smell and action (this, too, was shared with others), and a Listening Exercise in which trainees paired off in groups of three and alternately shared something important with a designated listener who repeated the gist of what the other had said in the presence of the third member who served as an observer-commentator. All of these exercises were designed to set a norm of sharing and self-disclosure, while also increasing the knowledge that the trainees had about each other.

With the fourth training session, we began focusing in succession on the helper variables. Because Carkhuff places so much emphasis on empathic understanding as a critical variable in helping, we devoted

five sessions to explaining and practicing empathy. With each of these variables, we presented hand-outs from Carkhuff describing his rating scale. Carkhuff conceives of levels of functioning 1 through 5 on each variable. Level 3 is presented as the minimally facilitative level for effective helping. The value of the rating scales are that they can be used to rate any helper intervention, they provide a baseline against which improvement can be determined and they facilitate teaching trainees to produce responses or interventions at a certain level instead of trying to produce one acceptably correct response. Besides the rating scale, a second hand-out detailed guidelines to successfully communicate each variable. To illustrate what the rating scales and the guidelines were like, we will use empathy as an example. At Level 1, the helper pays no attention at all to feelings, totally ignoring them. At Level 2, the helper noticeably subtracts affect from the feeling statements of the client. For example, a helper might respond to the statement, "I am simply furious with my boss. I'd like to hit him in the mouth." with, "You are a bit angry with your boss." At Level 3, the helper is interchangeable with the client on both feeling level and language. Any response demonstrating reflection of feeling would suffice as an example. At Level 4, the responses of the helper add noticeably to the expressions of the client in such a way that he can express feelings at a deeper level with added meaning. Level 5 is an extension of Level 4 with the helper's response adding significantly to the feeling and meaning of the client so that he can move on to new and additional feelings or self-explorations.

The hand-out of guidelines for communicating empathy stressed that the helper:

(1) concentrate on both verbal and non-verbal expression;

(2) attempt to reflect feelings and interact with the person seeking help;

(3) keep the language attuned to the helpee;

(4) move toward higher levels of empathy once an interchangeable base of communication has been established;

(5) concentrate upon what is not being expressed or what seems to be missing in what the helpee is saying.

In conjunction with discussion of the rating scale and guidelines to communication of empathy, the trainees viewed a videotape of one of the trainers interviewing an actress. The purpose of the tape viewing was to see an experienced interviewer demonstrate communication of empathy and to present to the trainees some responses which they could rate by level. Role playing was then used extensively to provide opportunities for the trainees to practice the communication of empathy, to criticize each other and to receive suggestions from the instructors. On a week-to-week basis, small group assignments were made so that each trainee had exposure to a variety of other trainees and instructors serving in both the help-giving and help-seeking roles. In these role play situations, emphasis was placed on having the help-seeker talk about a topic or personal experience about which he or she had strong feelings. These role play situations served to establish a norm of self-disclosure in the group which positively influenced group cohesiveness. The function of the helper in this situation was to practice recognizing and empathizing with feelings. An exercise that we found useful in increasing the skill of recognizing feelings was a videotaped session played to the trainees in which three actors depicted a range of feelings non-verbally. Given the range of possible feelings that

were being depicted on the tape, each trainee listed which feeling he thought was being expressed in each episode.

The instructors made periodic progress notes and subjective ratings about how each student-trainee was doing in communicating empathy. We chose to stay with this variable until we were assured that the trainees had a grasp of the concept, were becoming feeling-oriented and were capable of functioning at the minimally facilitative level. Once we were satisfied that this had been accomplished, we moved on to the other critical helping variables, beginning with communication of respect.

Our plan was to proceed in a step-wise fashion, adding another concept while encouraging people to continue using previously learned ones. In succession then we discussed, modeled, presented guidelines and rating scales and provided opportunities for practice in role playing situations each of the helper variables. (These hand-outs and subsequent ones were accumulated by the trainees in a loose-leaf workbook which the trainees retained for future reference as a sort of textbook.) Of the six, we covered concreteness and confrontation extensively over more than one session. We deemed these two skills to be especially critical to helping along with empathy and perhaps more difficult for the trainees to learn. Therefore, the additional expenditure of time in the training program seemed justified. For both concreteness and confrontation, videotaped sessions in which one of the instructors interviewed an actor were shown following presentation of the rating scales and guidelines. In addition, in the discussion of confrontation, the concept of feedback and its place in an inter-personal relationship were introduced and separate hand-outs detailing guidelines for giving and receiving feedback were discussed. Repeated opportunities were provi-

ded for the trainees to practice and improve their skills on each other. Communication of respect, genuineness, self-disclosure and immediacy of relationship were discussed in one session apiece.

Having completed and provided an overview of the interventions counselors make, i.e., the helper variables, we switched temporarily to a didactic focus in which an entire session or two were focused on a special topic. The first special session was on learning theory with special emphasis on effects of punishment and reinforcement in modifying behavior, presentation of the types of conditioning, discussion of behavior modification, relaxation training and assertive training. The point of this focus was to provide the trainees additional sound guidelines for their interventions. The next special topic was family relationships and family therapy (aided by hand-outs by Nathan Ackerman, "Prejudice and Scapegoating in the Family;" by George Bach and Peter Wyden, "Marital Fighting: A Guide to Love;" by John Williams, "Feedback Techniques in Marriage Counseling;" by Virginia Satir, "Techniques of Conjoint Family Therapy;" and by Haim Ginott, "How To Drive Your Child Sane.") The next special topic involved a discussion of how to recognize severity of disturbance, when, how, and where to make a referral (this discussion included a presentation of all the currently available community resources in the county), and how to recognize and what to do about depression and suicide. A rating scale was presented to determine severity of suicidal risk.

Throughout the course, we stressed the theme that the trainees be aware of their limitation; that they realize that they were not now qualified to handle everybody. We stressed the necessity of recognizing when a trainee was in over his head and when to consult or to refer to a professional person. The project director was available for consul-

tation at all times. The need to keep their qualifications in appropriate perspective had to be balanced with the necessity to encourage the trainees to have confidence in themselves and in the value of their helping efforts. In this context, trainee interpersonal skills were once again reviewed and compared to parameters of therapist activities provided by Gnostrom. The intent of the presentation was to indicate how many skills of professional therapists trainees did indeed possess as a result of this training experience.

The second phase of the training program was devoted to focusing on application of what the trainees had learned in skill sessions. Six meetings were arranged as supervision sessions. Each trainee was invited to discuss one particular person he had already been helping or to accept a referral if he (she) had not been seeing someone. The format called for discussion of problems in seeing helpees in which anyone could request time. Trainees received encouragement, positive strokes, ideas about what additional to do, etc., depending upon the individual situation. In addition, trainees were presented with additional opportunities for role plays in which they could further increase their interpersonal skills.

Toward the end of the second phase of the project, we hired an actress to serve as a programmed patient to be interviewed by each of the trainees. The actress was given an imaginary identity and some imaginary problems. The session was limited to 20 minutes maximum and was videotaped. The actress was provided with a scale on which she rated each trainee on the Carkhuff core conditions as well as provided some personal reactions to the interview style and helping skills of the trainee. The trainees knew that they were volunteering to see someone who was not a genuine patient. Fifteen agreed to the interview.

Though the original intent of this interview was to serve as a part of the evaluation procedure, it turned out to be a significant training experience for most. We also discovered a serious omission in the training program -- that we had overlooked any discussion of interview skills. We had been so keyed in on teaching people to be helpful that we forgot to teach them how to interview! We spent an entire training session on interviewing during which we provided an over-all outline of how to begin an interview, how to go about establishing rapport, how to get necessary information through asking open-ended questions and how to terminate the interview and provide a transition to a subsequent interview. In addition, one instructor interviewed another who role played a difficult help-seeker in a further effort to model good interviewing techniques.

We have not severed our relationship with the trainees. We have indicated to them that we are available to them on a continuing consulting basis. In addition, they have continuing access to the project director on his weekly visits to the Tipton area. In January, 1974, we had a one day refresher course for those trainees who wished to attend. Ten trainees came. The agenda for the day centered on member sharing of what they had been doing with what they had learned in the course, dissussion and problem solving related to how trainees can best make use of what they have learned, a review of the helper skills that they had learned, an opportunity for additional role play interviews in which they could further practice the helper skills and some more individual case supervision.

4. Training Program In Iowa County

We have discussed in detail the training project in Tipton, Iowa, which was our first effort. The Office of Child Development

approved funds for a second year. From October, 1973, through May of 1974, we conducted a similar training program for residents of Iowa County, which is also serviced by the Mid-Eastern Iowa Mental Health Center. In Tipton, we developed a training program as we went along. Our focus in Iowa County was to refine and improve upon our initial product. Nevertheless, the project in Iowa County was probably more similar than not to what we did in Cedar County. A problem we had to face in Iowa County that we did not have to face in Cedar County was where to hold the sessions. There is no one large population center in Iowa County such as Tipton is in Cedar County. We eventually chose a location, Williamsburg, which is at the approximate geographic center of the county. We again recruited 20 trainees from communities in the county using the guidelines that we wanted to include people who were already engaged in helping activities or who possessed natural helping skills. We met with the trainees for 18 sessions beginning on a weekly basis in the school in Williamsburg. Rather than describe in detail the training program as we have already done with Tipton, we shall instead merely point out some of the differences between what happened in Williamsburg and what happened in Tipton.

A. In the Williamsburg project we had helpers from various communities that were geographically separated. This made for a less cohesive group because people did not know each other as well nor did they see each other regularly outside the training sessions.

B. The trainee group was older in Williamsburg than it was in Tipton. This is relevant to the extent that we have now trained both high school students and senior citizens. I think it is important to point out that a training program such as this has relevance to all ages and that the retired can benefit as much as the young.

C. It was our impression that the trainees were more business-like, pragmatic and goal-oriented in their approach to the sessions. It is difficult to sort out exactly what led to this difference. Probably several factors are involved. We were aware of a greater staff-trainee gap in this group. Possibly we came on more sure of ourselves and more certain about what we were doing. Possibly people came in response to our advertising something that we had to offer and busily went about acquiring it. Possibly the fact that people came from various geographic centers contributed to the atmosphere of the sessions. At any rate, we think that this is worth pointing out to those who will do a project like this more than once.

D. We made much greater use of videotape in our training program in Williamsburg than we had in Tipton. I think we were influenced by the micro-counseling approach of Ivey. The essential features of the micro-counseling approach are to present a helper variable to a trainee, then immediately provide an opportunity to practice this skill in a role play situation which is videotaped. The videotape is immediately replayed to the trainee to give him some idea of how he is doing on the skill involved and what needs to be improved. We found that the videotape was a very useful adjunct to the training efforts of the staff.

E. By this time we have developed a much better and extensive library than we had available to us in Tipton. We provided a library list to each of the trainees and purchased copies of each of the books and made them available to the trainees on a loan basis. To the extent that they were motivated, the trainees had opportunity to engage in additional readings related to the material that was being discussed in each session.

F. In the Tipton training project, we had accumulated a group of

associated readings which we put together into a trainee textbook. In Tipton we passed out the readings as we stumbled upon them. In Williamsburg, we gave the people all the readings at the beginning of the class. This permitted them to read on ahead at their own pace. The advantage of the trainee's textbook is that at the conclusion of the training program the trainees have some material to which they can refer back and to consult when a problem occurs in working with a help-seeker.

5. Alternative Formats

Derived from our experience in Cedar and Iowa Counties, we presented a workshop entitled, "Improving Helper Effectiveness." We attempted to boil down the essentials of the training program to fit a two-day time span, which was done July 18 and 19. We focused on critical helping skills: listening and attending, being alert to verbal and non-verbal behavior, expressing and receiving feelings, and the helper variables discussed earlier as described by Carkhuff. The format included a description of a particular helping skill and guidelines in a mini-lecture, written handouts, opportunity to practice the skill in a role play with videotape playback and discussion. Twenty persons attended the workshop, all in positions of being helpers to families and children.

The workshop was evaluated through diaries we asked the trainees to keep and to turn in at the end. They felt that most learning occurred during discussion of their videotaped role plays. They appreciated the handouts, thought the staff worked well together, and said the workshop was a positive and helpful experience.

In another format, we met twice in June, 1974, with a group of young and older adults from the Coralville, Iowa Methodist Church.

In the first session, we presented a short lecture on listening and then invited the audience to practice listening skills with each other and to give feedback on the quality of their listening. In the second session we focused on empathy, using the same procedure. These presentations were quite favorably received by the parishioners.

RURAL COMMUNITIES LEARN TO HELP THEMSELVES

III. Assessment of Effectiveness of Training Program

One of the unusual features of this project, which distinguishes it from its predecessor at Susanville, is the number of evaluation techniques included to assess the effectiveness of the training program and its impact on the individual trainees. The same evaluation instruments were utilized both at Tipton and at Williamsburg. They included the Personal Orientation Inventory, the Discrimination and Communication indices developed by Carkhuff, checklists from programmed patients who were interviewed by the trainees and personal report statements made by the trainees in their diaries. The results of each of these test instruments will be discussed in succession.

The Personal Orientation Inventory is an objective test developed by Everett Shostrom, which shows the degree to which the values of the test taker compare with those of self-actualizing people. A self-actualizing person is defined as one who is more fully functioning and who lives a more enriched life than does the average person. Such a person is developing and utilizing his unique talents to the fullest extent. It was our expectation that this test would serve as a measure of some characteristics of good helpers.

The POI was administered on a pre and post basis to all of the participants in the training projects in Tipton and in Williamsburg. Commenting briefly on the characteristics of the group as a whole on pre-testing, no remarkable or distinguishing characteristics with respect to any of the measures of self-actualization were obtained. The group as a whole appeared to be fairly average and "healthy." No typical file was discernible. As might be expected, there were individual variations true for all the dimensions of the POI. This may partially be interpreted as some indication of the heterogeneous nature of this group.

One striking feature of the comparison between pre- and post-testing was the marked similarity in results obtained in the two independent samples. Significant changes occurred between pre and post findings in six different scales with five of the scales identical in both populations. Significant changes were noted in an increased degree of Inner-directedness (defined as self-support, independence, leaning less on others), a corresponding reduction in Other-directedness (defined as dependent, seeking support from others, conforming), an increase in the scale measuring Self-actualizing values (indicative of the fact that the trainees held more of the values of self-actualizing people following training), an increase in Exustentiality (which is sort of a measure of flexibility-rigidity), an increase in Self-acceptance (defined as being able to accept the self in spite of weaknesses). Two other scales showed changes, but were not consistent from one sample to the other. At Tipton, the trainees showed a significant increase in the scale measuring Capacity for

intimate contact (defined as accepting and having warm interpersonal relationships); the trainees at Williamsburg showed a significant increase in the scale measuring Acceptance of aggression (a scale measuring willingness to accept feelings of anger or aggression in self). The POI has frequently been advanced and used as a measure of outcome in psychotherapy. This project was designed as an educational experience, not a therapeutic one. Nevertheless, we find it highly noteworthy that changes in measured self-actualization occurred in many of the trainees. These findings yield indications of a possibly unexpected impact of the program in that we did not attempt to provide a therapeutic experience to these trainees.

Carkhuff has made frequent use of two separate measures, Discrimination Level and Communication Level, in evaluating the effectiveness of his many training programs. Both measures are based on the presentation of sixteen excerpts from help-seekers. The excerpts have been transcribed onto audio tape. In the Communication exercise, the trainees were directed to produce whatever response they thought would be helpful to the person who had just said these things to him. This response produced spontaneously by the trainee was then "graded" on a scale ranging from one to five measuring effectiveness of the response. On this cale, three was defined as average or "minimally helpful" with scores below three being less effective and those above three being more effective. For purposes of this project, two graduate students in Clinical Psychology received training in the Carkhuff methodology and practice at rating the effectiveness of responses produced by

counselors. Each of them independently were given the responses produced in the communication exercise by the trainees at Tipton and Williamsburg. They rated these responses on the scale from one to five without knowledge of the identity of the person who produced the response. The Discrimination exercise also derives from the same 16 helpee situations. The measure differs in that the trainee was presented with four possible responses to each of the 16 situations. The task of the trainees was to rate the effectiveness of the response on the one to five scale described above. The response is scored by the extent of deviation from ratings produced by Carkhuff's expert judges. Therefore, a lower score indicates closer agreement with these judges. The point of the two measures, then, is that in the Communication exercise the trainee was required to produce his own response to the person seeking help whereas in the Discrimination exercise the trainee was required to differentiate good from poor responses made by someone else. Both measures are important in assessing effectiveness of helpers, but the Communication exercise is more useful in that it measures the ability of an individual to produce his own helping responses. Both the Communication exercise and the Discrimination exercise were administered on a pre and post basis to all the trainees at Tipton and Williamsburg. The measures permit us to evaluate the effectiveness of the helping skills of the trainees before any exposure to the training program and the corresponding effectiveness after their exposure to the training program.

Scorable Discrimination exercises were obtained from 20

trainees pre and post at Tipton and 11 trainees at Williamsburg. At Tipton, the corresponding means for the group prior and subsequent to the training program were 0.98 and 0.83. A t-test performed on the difference between these means was significant at $p < .01$. For the Williamsburg sample, the mean for the tested group prior to the training program was 1.11 and the mean for the same subjects subsequent to the training program was 0.99. This result was also significantly different by t-test at $p < .05$. Seventeen of the 20 subjects at Tipton showed a decrease in their discrimination level whereas eight of the eleven subjects at Williamsburg showed a decrease in their discrimination level. For comparative purposes, it might be illustrative to present some normative data provided by Carkhuff for other populations. According to Carkhuff, the typical score for the general population on the discrimination measure is in the range of 1.4 to 1.5, the lay-counselors score in the neighborhood of 1.2, professionally trained counselors score around 0.6. Comparing these norms to our samples, it is evident that this group started at a level better than lay counselors before training and scored much lower than that at the end of training. Four trainees at Tipton and two at Williamsburg obtained scores which would make them comparable to professionally trained counselors. Thus, it would appear from the results of the Discrimination measure that training did increase the effectiveness of the group in its ability to recognize good helping responses.

Looking at the results of the Communication exercise, nineteen trainees at Tipton obtained a mean score of 1.92 prior to the

onset of training and a mean score of 2.44 subsequent to training. This result was significantly different by a t-test at $p < .01$. Comparable scores on the communication exercise were obtained at Williamsburg. The mean of the group on pre-testing was 1.98 and the mean of the group on post-testing was 2.75. This result was also significantly different by a t-test at $p < .01$. As indicated earlier, the results of the Communication exercise are perhaps more critical in that this task is measuring the ability of the subject to produce his own helping responses. The results of the Communication exercise clearly indicate that trainees at both Tipton and Williamsburg were significantly more effective in the quality of responses they produced. As mentioned earlier, a level of 3.0 is regarded as "minimally helpful" in working with people. Some trainees did much better than the minimally helpful level and some did somewhat worse, but the mean of the entire group is not too far removed from this minimally helpful level.

Another way of looking at the results of the Communication exercise was to rank order the subjects within the group as to their relative standing pre and post. Then a correlation measure was run to check the extent to which the trainees fell in approximately the same positions in the distribution before and after training. The result of this correlation was highly significant ($p < .01$). This finding suggests that pre-testing measures on Communication and Discrimination could have been used as selection criteria in this project. Carkhuff has made the same point in his own work. With few exceptions, the subjects who started as our "better" helpers ended up as our "best" counselors and those who started out as not so effective ended up as less effective. Never-

theless, it is important to note that the entire sample increased in effectiveness. This finding is of greatest applicability in a situation where someone else would choose to run a training program such as ours and have an abundance of applicants. In such a situation, it would make sense to do pre-screening and select the trainees to be included on the basis of the test findings.

In both projects, partly as an educational exercise for the trainees and partly as an outcome measure, we included programmed patients who were interviewed by the trainees after they had completed the training program. In the Tipton project we used one programmed patient and in the Williamsburg project we used two. In each instance, the programmed patient was played by a hired actress who was given an imaginary identity and an imaginary set of problems by the trainers. The purpose was to have the trainees do a counseling interview with the programmed patient and to obtain organized feedback from the programmed patient about the effectiveness of the trainee in that situation. In both Tipton and Williamsburg, approximately one-half of the trainees were judged to be effective on the rating scale completed by the programmed patient. As might be anticipated there was a high degree of correlation between the counselor rated to be effective in the programmed patient interview and the results of the Communication exercise. It is encouraging to note that the people who were identified as helpful by the test instruments were also rated as being helpful in an actual interview situation with a "client."

A final way of assessing effectiveness of the program was to obtain some trainee reactions to the training program. All of

the trainees and the instructors were asked to keep a diary detailing their reactions to the training experience as it unfolded. The summary comments were generally favorable and enthusiastic. Selective representative comments have been excerpted and are included below:

Trainee #1 - a housewife. "I feel on top of situations I could not deal with before. For me, personally, I have gained a stronger self; I am more able to express my feelings. I do think I have been able to help (name deleted) because of this program. This is largely because I became far less afraid of people's emotions."

Trainee #2 - a nurse. "It was a tremendous learning experience and much knowledge was gained which will be of great help to me in my work. This training course has taught me how to listen -- what is the other person saying? I am more open-minded and less judgmental. In dealing with personal problems, I have learned that individuals must face up to problems. They have to see the present problem as it stands now, and not dwell on something from the past."

Trainee #3 - a female social worker. "This program has made me more aware of my feelings and other people's feelings. The course has probably helped my personal life more than my professional life in that in my professional relationships I am more aware of the other. I learned to use feedback more."

Trainee #4 - a male minister. "I continually have opportunity for counseling in the everyday relationships of my profession, and I find myself attempting to use some of the ideas

which have been shared with us. They have been helpful and I feel that I am doing a better job. The course was great and I do feel more capable to deal with some of the problems that I come face to face with."

All of the outcome measures have consistently pointed in the direction of improved effectiveness on the part of the majority of the trainees in helping situations. At a reasonably moderate cost in time and money, it has been proven possible to produce some effective lay helpers.

IV. OVERVIEW OF THE PROJECT AND IMPLICATIONS FOR THE FUTURE

We began with a dream and the fond hope that a short-term training project with lay people would prove to be feasible. When we began, we had no structured training program, but had to develop one as we progressed. Admittedly, we owe a great debt to Carkhuff, for his core conditions of helping eventually became the cornerstone of the training program.

One of the implications of this project is that lay people can be trained to function effectively as helpers. It would seem to us that the function of a local mental health center can be expanded to include a training function. Our particular Center's board has agreed to budget for training in the forthcoming financial year.

Another effect of the project is that it has stimulated one of the trainers (Patricia Kelley) to develop a social work skills course at the University of Iowa School of Social Work.

We have described the program to various professional groups that have included: 1) Institute on Community Mental Health Service Delivery in Rural Areas sponsored by the State Mental Health Authorities of Iowa, Kansas, Missouri, and Nebraska; 2) The Community Mental Health Centers Association of Iowa, with attendance from 30 mental health centers in Iowa; 3) The Southeast Iowa Chapter, National Association of Social Workers; and 4) two presentations to graduate students of the University of Iowa School of Social Work. Twice we have been turned down by the American Orthopsychiatric Association to present a paper at their national meeting, saying that it was not germane to their theme. Recently, we have submitted an abstract of a paper for the Twentieth Anniversary NASW Professional Symposium on Social Work Skills.

We had hoped for another year of OCD funding, the purpose being to develop a training program suitable for broadcast over educational television. Unfortunately we were turned down. We have been exploring other sources of funding for this idea but have not been successful.

Finally we feel that we have demonstrated successfully that community helpers can be trained to be effective in rural service delivery to families and children. We have enjoyed the project and appreciate the assistance extended by the Office of Child Development.